Dial-In Instructions

Conference Name:	**Realize the Benefits of Restorative Nursing: How to improve reimbursement and your residents' quality of life**
Scheduled Conference Date:	**Friday, September 24, 2004**
Scheduled Conference Time:	**1:00 p.m.–2:30 p.m. (Eastern), 12:00 p.m.–1:30 p.m. (Central), 11:00 a.m.–12:30 p.m. (Mountain),10:00 a.m.–11:30 a.m (Pacific); 9:00 am - 10:30 am ADT (Alaska); 8:00 am - 9:30 am H/AST (Hawaii-Aleutian)**
Scheduled Conference Duration:	**90 Minutes**

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2. If you prefer not to ask your question on the air, you can fax your question to **1-877-865-4210** or **1-973-237-3904.** (Please note: You can only fax your question during the program.)

Prior to the program
If you prefer not to ask your question on the air, you can send your questions via email to *sdunn@hcpro.com.* Cutoff date and time for questions: **09/23/04 @ 5:30 PM EST..** Please note that not all questions will be answered.

Program Evaluation Survey
In your materials on page 2, we have included a Program evaluation letter that has the URL link to our program survey. We would appreciate it if when you return to your office you could go to the link provided and complete the survey.

Continuing Education documentation
If CE's are offered with this program a separate link containing important information will be provided along with the program materials. Please follow the instructions provided in the CE Documentation.

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Program Evaluation

Dear Audioconference Participant,

Thank you for attending the HCPro audioconference today. We hope that you find the information provided valuable.

In our effort to ensure that our customers have a positive experience when taking part in our audioconferences we are requesting your feedback. We would also like to request that you forward the link to others in your facility that attended the audioconference.

We realize that your time is valuable, so we've limited the evaluation to nine multiple-choice questions. Please click on the link below.

http://www.zoomerang.com/survey.zgi?p=WEB2QF5RK36A

The information provided from the evaluation is crucial towards our goal of delivering the best possible products and services.

We appreciate your time and suggestions. We hope that you will continue to rely on HCPro audioconferences as an important resource for pertinent and timely information.

Sincerely,

Frank Morello
Director of Multimedia
HCPro, Inc.

PPS Alert for Long-Term Care
A Survival Tool for the MDS or RN Coordinator

presents . . .

Realize the Benefits of Restorative Nursing: How to Improve Reimbursement and Your Residents' Quality of Life

A 90-minute interactive audioconference

Friday, September 24, 2004

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)

In our materials we strive to provide our audience with useful, timely information. The live audioconference will follow the enclosed agenda. Occasionally our speakers will refer to the materials enclosed. We have noticed that other non-HCPro audioconference materials follow the speaker's presentation bullet-by-bullet, page-by-page. Because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker's entire presentation. The materials contain helpful forms, crosswalks, policies, charts, and graphs. We hope that you find this information useful in the future.

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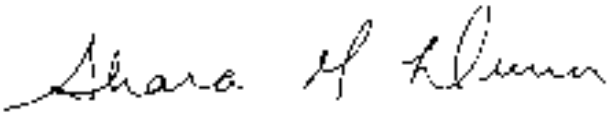
Dear colleague,

Thank you for participating in our **Realize the Benefits of Restorative Nursing: How to Improve Reimbursement and Your Residents Quality of Life** audioconference with **B.J. Collard, RN, BSN, GNP, ANP, CPHQ** and **Janie Krechting, BSN, RN, C., MGS, LNHA,** moderated by **Noelle Shough.** We are excited about the opportunity to interact with you directly and encourage you to take advantage of the opportunity to ask our experts your questions during the audioconference. If you would like to submit a question before the audioconference, please send it to *sdunn@hcpro.com* and provide the program date in the subject line. We cannot guarantee your question will be answered during the program, but we will do our best to take a good cross section of questions.

If at any time you have comments, suggestions, or ideas about how we might improve our audioconference, or if you have any questions about the audioconference itself, please do not hesitate to contact me. And if you would like any additional information about other products and services, please contact our Customer Service Department at 800/650-6787.

Thanks again for working with us.

Best regards,



Shara M. Dunn
Audio/Web Conference Coordinator
Fax: 781/639-2982
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Exhibit B 11

Restorative nursing tools provided by Janie Krechting:
Restorative nursing program components checklist
Restorative nursing programs chart
Restorative reimbursement analysis chart
Restorative program: Eating checklist and progress table
Restorative nursing referral form
Restorative nursing assignment sheet and master list

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Restorative nursing tools provided by B.J. Collard:
The four P's of restorative nursing
Roles and responsibilities in restorative nursing
Restorative nursing transfer and documentation form
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Agenda

1. Overview of restorative nursing

2. Documentation requirements

3. Reimbursement considerations

4. Quality indicators to measure success and improvement areas

Q&A

About your sponsors

About HCPro, Inc.

HCPro is the premier healthcare information and resource provider on compliance and regulatory issues faced by hospitals, home-health organizations, nursing homes, physicians' offices and other healthcare facilities. HCPro has launched a number of Web "supersites" that include tips, how-to information, "ask the expert columns," free e-mail newsletters, and so much more.

About *PPS Alert for Long-Term Care*

Survey deficiencies, the DAVE project quality measures–every time you turn around, CMS has found a new way to test under MDS accuracy. Let **PPS Alert for Long-Term Care** help you pass with flying colors! **PPS Alert for Long-Term Care** is your resource to navigate the confusing world of the MDS and keep you in the loop on CMS' latest initiatives.

Created exclusively for the MDS coordinator or RNAC, long-term care administrator, and director of nursing, this dynamic publication will become your survival guide when it comes to complying with PPS. It also gives you the latest compliance tips, news, and analyses regarding MDS coding, timing, and scheduling.

Plus, you'll love our most popular feature in this 12-page monthly resource, the PPS Q&A column from noted expert, Julia Hopp, MS, RN, CNAA, BC.

PPS Alert for Long-Term Care is a user-friendly tool that will lead you successfully through the MDS by offering tips on the best coding and documentation methods to getting the reimbursement you deserve.

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Speaker profiles

Noelle Shough (moderator)

Noelle Shough is a senior managing editor in the long-term care group. Besides manning the helm of the newsletter **PPS Alert for Long-Term Care,** she edits books, newsletters, and e-zines, as well as manages quality for the group. In her four-and-a-half year stint at HCPro, she has also written and researched in the areas of rehabilitation, credentialing, patient safety, nurse management, physician practices, and compliance.

Janie Krechting, BSN, RN, C., MGS, LNHA

Janie Krechting, BSN, RN, C., MGS, LNHA, is a clinical consultant with expertise is on OBRA compliance, PPS/RUGS III, MDS/RAI, quality improvement, assessment, documentation, care planning, management and supervision. Krechting is also an assistant professor in aging services and administration at the College of Mount St. Joseph in Cincinnati. She is also the author of the books *Clinically Based Long-Term Care Survey Preparation Guide Manual and Interdisciplinary Care Plans for Long-Term Care,* and the *Quick Guide to Documentation*.

BJ Collard, RN, BSN, GNP, ANP, CPHQ

BJ Collard, RN, BSN, GNP, ANP, CPHQ, is founder of CTS Inc, a nurse consultation and education firm in Denver, which specialized in post acute care. CTS provides consultation services and workshops for organizations, corporations and individuals. Collard is an expert on OBRA compliance, PPS/RUGS III, MDS/RAI, JCAHO, quality improvement, assessment, documentation, care planning, management and supervision. Collard developed and has presenting for 13 years a DON Training Program for corporations and individuals.

BJ is a recognized authority on restorative nursing, having successfully completed a grant awarded to her from the Federal Administration on Aging to develop a model for systematic delivery of restorative nursing care to clients in post acute care settings. This model has become the prototype used by all organizations to implement comprehensive, successful restorative nursing programs. Collard contracts with corporations to perform restorative nursing program analysis, and directs program revision, development and system implementation based on identified strengths and improvement areas.

Collard is a charter member of AANAC and serves on AANAC's board of directors.

Collard has authored many publications, and her two most popular manuals are the *Restorative Nursing Manual* and the *Quality Improvement Manual for LTC. The Restorative Nursing Manual* is a practical guide that will assist facility staff to provide restorative care in a systematic, planned manner that enhances individual resident quality of life, meets RUGS III/ PPS payment criteria and achieves CMS compliance with OBRA regulations. *The Quality Improvement Manual* provides tools, forms and resources to set up a facility quality improvement program. The manual includes a chapter on a process on how to use the quality indicator data and reports to perform root cause analysis. All of the OBRA regulations are set up as QI tools and can be used as a resource for learning the regulations, as well as to perform a mock survey self assessment.

Exhibit A

Presentation by B.J. Collard, RN, BSN, GNP, ANP, CPHQ and Janie Krechting, BSN, RN, C., MGS, LNHA

Agenda:

1. Overview of restorative nursing

2. Documentation requirements

3. Reimbursement considerations

4. Quality indicators to measure success and improvement areas

Realize the Benefits of Restorative Nursing:

How to improve reimbursement and your residents' quality of life

September 24, 2004

B.J. Collard, RN, BSN, GNP, ANP, CPHQ
and
Janie Krechting, BSN, RN, C., MGS, LNHA

1

What is Restorative Nursing?

- Not to be confused with formalized therapy services that are provided by or under the direction of qualified therapists – speech/language pathology, occupational therapy and physical therapy
- Restorative Nursing is a Nursing function

2

What is Restorative Nursing

CMS Definition:

Rehabilitation or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, & psychosocial functioning.

3

What is a Restorative Nursing Program?

- MDS section p3 (* = 1 program vs. two)
  - Passive or active ROM
  - Splint or brace assistance
  - Bed mobility*
  - Transfer*
  - Walking*
  - Dressing/grooming*
  - Eating/swallowing*
  - Amputation/prosthesis care*
  - Communication training*
  - Toileting or bladder retraining

4

What is a Restorative Nursing Program?

THE FOUR P's

- Promoting
- Preserving
- Preventing
- Preparing

5

What is a Restorative Nursing Program?

- A specific approach that is organized, planned, documented, monitored and evaluated

6

What is a Restorative Nursing Program?

- Prescription for a Program

1. What is to be done?
2. What specific equipment, staff assistance, etc.?
3. Who is to do it?
4. When, where?

7

What is a Restorative Nursing Program?

- Program Classifications:
  - Improve function
    - Progressive
  - Maintain function
    - Functional maintenance
    - Skills practice
  - Prevent decline or slow decline
    - Functional modify

8

What is a Restorative Nursing Program?

What if no expectations of improvement?

- Is this a program?
- Yes!
- A few examples

9

What Residents Need a Restorative Program

- A resident who is unable to perform an ADL function or segments of a function independently, at a point in time, bust has potential for:
  - Independent task or subtask performance
  - Maintaining task or subtask function with staff intervention
  - Preventing or slowing decline with staff intervention

10

RESIDENT PROFILES FOR PROGRAM CLASSIFICATIONS

11

When is the Best Time to Provide Programs?

- Dependent upon the resident
  - Individualize schedule
  - Sleeping patterns
  - Peak performance
- All shift involvement 24/7
  - Day shift
  - Evening shift
  - Night shift

12

Why is it Necessary to Provide Restorative Care?

- Resident dignity & self worth
- Increased staff morale
- Federal government regulations
- Reimbursement
- Decrease in staff time for ADL
- Marketing opportunity, enhanced reputation

13

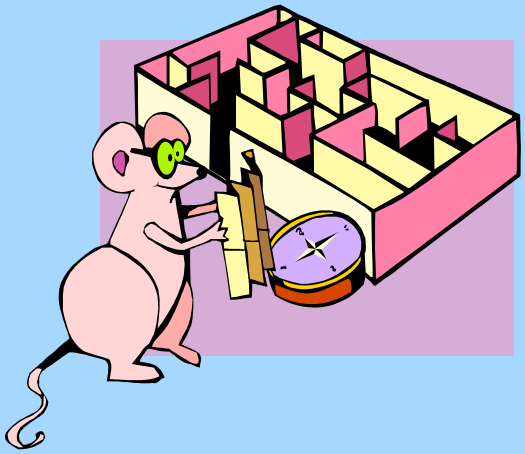
WHO Identifies Restorative Needs & Starts Programs?

- Therapy
- Nursing

14

Who Directs the Program? Who Does What?

- Restorative nurse coordinator
- Nurses
- CNAs
- Therapy
- MDS Coordinator
- Social Services
- Activities
- DON
- Administrator



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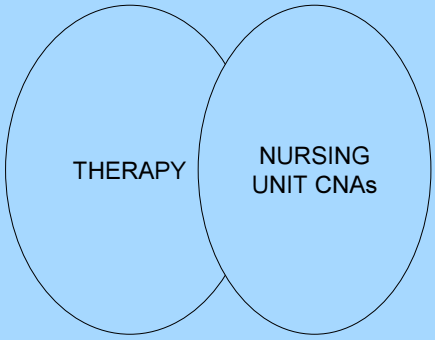
How to Deliver Restorative Care

Which model is best?

- No designated RCNAs versus designated restorative CNAs – 2 levels

No designated RCNAs



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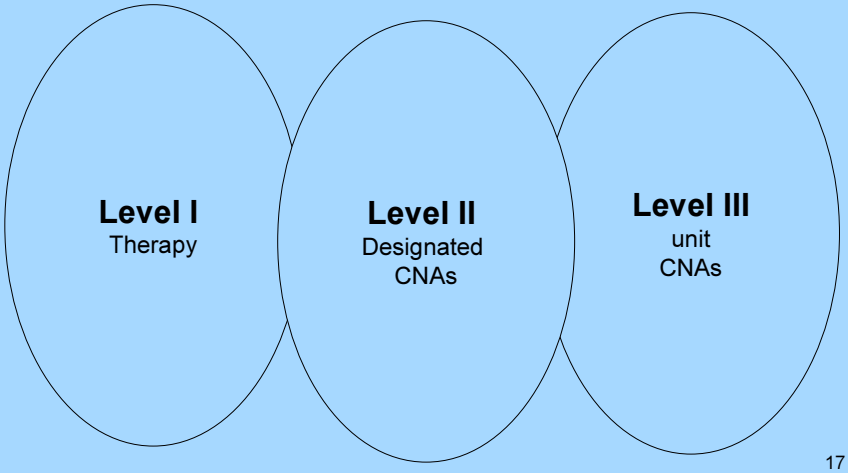
Designated Restorative CNAs
3 Levels



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How to Deliver Restorative Care

Which model is best?

Designated restorative CNAs	No designated restorative CNAs
- High therapy usage - Large facility - Unit CNAs are still involved	- Low therapy usage - Small facility – 80 beds and below - All CNAs equally involved

18

Roles Level II & III CNAs

- LEVEL II
  - Stabilize the program before transfer to Level III
  - Work with challenging residents indefinitely
  - Perform therapy delegated tasks
- LEVEL III
  - Maintenance

19

How Do You Organize an Individual Resident Program?

- Staff need to know who is on a program and program specifics – program structure:
  - Master list
  - CAN assignment sheet
  - Communication systems
  - Care plan
- Staff need to document the program – program structure:
  - Flow sheets
  - Narrative note designated area

20

How Do You Organize an Individual Resident Program?

- Staff need to know vulnerable times when residents are at risk for ADL decline – program structure:
  - Admission – no therapy – nursing assessment, therapy screening
  - Resident non program performance – reporting protocol
  - Program transitions – transfer procedure
  - Acute problem development – nursing assessment
  - Hospice, end of life – nursing assessment

21

How Do You Organize a Facility Program?

- Staff need to take ownership – organization structure:
  - Philosophy
  - Committee or task force
  - All staff involvement, restorative culture
  - Staff motivation, resident motivation
- Staff need to know their role and how to perform Restorative techniques and practices – organization structure:
  - Job descriptions
  - Policies & procedures
  - Orientation, ongoing training & education
  - Skills competency

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How Do You Organize a Facility Program?

- Staff need to know Restorative care is taken seriously and they are expected to follow through – organization structure:
  - Accountability – tracking & monitoring
  - Call in policy
- Nursing management & administration need to know program outcomes, program function – organization structure:
  - Quality indicators
  - Quality measures

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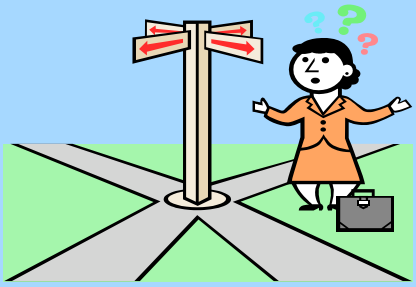
WHAT? WHO? WHERE? WHEN? WHY? HOW?



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Restorative Nursing Requires a Team

My supervisxr txld me that team wxrk depends xn the performance xf every single persxn xn the team. I ignxred that idea until my supervisxr shxwed hxw the xffice typewriter perfxrms when just xne single key is xut of xrder. All the xther keys wxrk just fine except xne, But that xne destrxys the effectiveness xf the typewriter. Nxw I knxw that even thxugh I am xnly xne persxn, I am needed if the team is tx wxrk as a successful team shxuld.

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Restorative Programs

Janie Krechting
Assistant Professor
College of Mount St. Joseph

26

Structure, Process and Systems and Restorative Documentation

Structure

- Policies and procedures
- Training\orientation
- Tools
  - Forms
  - Restorative equipment
  - Restorative monitors

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Process- Identify and train individuals in positions required to document

- Restorative nurse
- Restorative aide
- Activity staff or other staff trained to deliver restorative nursing program

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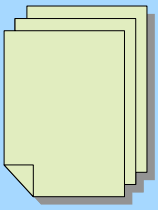
Required documents



- Restorative nursing assessment
- Restorative care plan
- Delivery record
- Progress note

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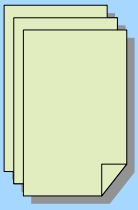
Other required documents



- Documentation to support training and competency of restorative nursing assistants delivering care

30

"Let's start from the very beginning – it's a very good place to start"

Identify residents appropriate for restorative nursing assessment then utilize documents/forms/communication tools

- Therapy to nursing form
  (A form that notifies nursing of residents appropriate for evaluation)
- New admission – process should include
  (an evaluation form or documentation of need for restorative program)
- Resident changes indicating need for new restorative nursing evaluation
  (form or process for communication with restorative nurse)

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Which documents, by whom and when ???????

- A restorative assessment completed by qualified restorative nurse upon referral
- A restorative care plan developed by the restorative nurse to reflect individual resident's assessed needs
- A delivery record completed by restorative nursing assistants/trained activity assistants after each session
- A progress note by restorative nurse –(monthly and/or quarterly note) Not a co-signature

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Restorative Nursing Documentation Process

Data Gathering

⇩

Assessment (Analysis)

Evaluation — Care Plan

Implementation Documentation

(2 programs;15 minutes; 6 days per week)

33

Data Gathering Process

- Observation
- Interview
- Documentation
  - Hospital discharge records
  - Therapy notes
  - Flow records
  - Nursing notes
  - Delivery record
  - Nursing progress note

34

Assessment

- Assessment tool choices
  - Narrative assessment
  - Assessment tool
    - Generic
    - Specific to condition being assessed

35

Assessment Content

- Consider strengths and weaknesses
- Risks and potential complicating factors
- Restorative program or maintenance
- Resident-specific deficit indicating need for restorative program

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Restorative Care Plan Documentation

- Problem = PES
  - Problem statement = General category
  - Etiology = Risk factors, reasons for problem and contributing factors
  - Symptom = Detailed description
- Goal
  - Measurable = key to progress measurement
  - Target date
- Interventions
  - What will be done, schedule and who
  - What equipment will be used, schedule
  - Resident teaching/education to occur

37

Restorative Care Plan Problem Statement Example

- Self-care deficit – Eating
- Related to
  - Loose dentures
  - Right hemiplegia – history of right hand dominant
- As evidenced by
  - Food falls off plate when scooping with spoon
  - Difficulty chewing meat
  - Difficulty piercing food

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Restorative Care Plan Goal Statement Example

- Resident will be able to:
  - scoop soft items with spoon without pushing off plate
  - chew meat
  - pierce food

by target date

39

Restorative Care Plan Intervention Example

- Place resident in restorative eating program each meal 7 day per week
- Use plate guard
- Coordinate dental referral

- Provide mechanical soft diet until ability to chew meat demonstrated

- Teach resident piercing skills

40

Scheduling the lost link

- Facility schedule
  - Meals
  - Bath
  - Activities
- Documentation of resident scheduling – must be coordinated with facility schedule
  e.g., range of motion requirements, dictate schedule

41

Steps to maximizing RUGs III restorative nursing reimbursement

- Identify residents whose RUGS score falls into categories impacting reimbursement
- Identify residents who only have one restorative program
- Review residents with significant changes

42

Restorative Reimbursement

Identify residents that fall in the categories in which restorative nursing has an impact.

- Rehabilitation low
- Impaired cognition
- Behavior impaired
- Reduced physical functioning

43

Group therapy

- What is it? – The delivery of restorative services in a group setting
- MDS criteria – No more than 4 persons per restorative nursing assistant
- Implementation considerations -
  - Daily scheduling of resident's ADL's
  - Staff communication and coordination

44

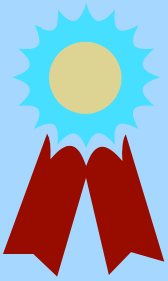
Costs of not having a high quality restorative nursing program

- Higher acuity
- Quality of life
- Depression
- Lost restorative reimbursement
- Survey citations
- Census/reputation

45

QI to Measure Success

- Identify & celebrate staff efforts, successes
- Illustrate what you are doing right



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QI to Identify Improvement Areas

- Ongoing to see how you are doing – planned, systematic analysis
- Two excellent tools
  - Quality indicators
  - Quality measures
- Benchmarking

47

QI to Identify Improvement Areas

- Enhance best practices
- Maintain systems that function as planned & expected
- Sustain delivery of quality of care and compliance over time

48

THAT'S ALL, FOLKS! HOPE THIS WAS HELPFUL!

49

Exhibit B

Restorative nursing tools provided by Janie Krechting
"Restorative nursing program components checklist"
"Restorative nursing programs chart"
"Restorative reimbursement analysis chart"
"Restorative program: Eating checklist and progress table"
"Restorative nursing referral form"
"Restorative nursing assignment sheet and master list"

Source: *Permission to reprint by Janie Krechting, BSN, RN, C., MGS, LNHA.*

Restorative Nursing Program Components

Each of the following components are required for the establishment of a restorative nursing program

- An assessment which:
  - Demonstrates the need for the program
  - Is completed by a Licensed nurse
  - Does not include procedures or techniques carried out by or under the direction of qualified therapists
- A care plan which:
  - Includes measurable goals/objectives
  - Includes specific interventions for the need identified through the assessment
- A service delivery record which:
  - Demonstrates service delivery at least 15 minutes a day
    6 days per week
- A clinical record which:
  - Demonstrates evidence of periodic evaluation by the licensed nurse
- Evidence that the nursing assistants/aides have been trained in the techniques that promote resident involvement in the activity
  - Service delivery that demonstrates: Training and skill practice - Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.
  - Evidence that the nursing assistants/aides have been trained in the techniques that promote resident involvement in the activity
  - Carried out by nursing staff
    Or
  - Presence of supervision by the nursing staff
  - No more than 4 residents per group
- For reimbursement purposes, there must be 2 restorative nursing programs

Consider the following when assessing the resident

- Does the resident have the ability to learn?
- To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status?

Restorative Nursing Programs

Range of Motion (Note – Only one counts as a restorative program for RUGS)		Eating or Swallowing (Dining)	Walking Ambulation	Bed Mobility	Bladder Training	Toilet in Advance of Need or	Dressing	Grooming
Active	Passive		(Note – Only one counts as a restorative program for RUGS)		ADL's (Note – Only one counts as a restorative program for RUGS)		ADL's (Note – Only one counts as a restorative program for RUGS)	
Total __		Total __	Total __	Total __	Total __	Total __	Total __	

Amputation or Prosthesis Care	Communication	Transfer Training	Brace or splint assistance (Contracture Management	
Total ____	Total ____	Total ____	Total ____	

Total Programs ___

Restorative Reimbursement Analysis Chart

List Residents who fall in the impaired cognition, behavior impaired or reduced physical functioning (or who meet the rehabilitation low therapy requirement)

Resident's Name	RUGS Category				Restorative Program 1 (list)	Restorative Program 2 (list)	Potential for additional programs if one (List program)	Potential for 2 programs if none (List programs)
	Rehab low	Cognition Impaired	Behavior Impaired	Reduced Physical Function				

Restorative Program: Eating

Assessment: Eating

Factors impacting eating skills

Fine motor skills impaired Hemiplegia right left Pain Vision impaired

Eating skills: Holds cup Brings cup/glass to mouth Pierces food with fork Scoops food with spoon

Staff support:: Supervision Cues Demonstration One person Resident eats ____ % of meal.

Devices: Built-up: Spoon Fork Knife Rocker: Spoon Fork Knife Plate guard Non-skid device under plate Cup: Sippe Deep dish plate _____

_____

_____

_____

Problem/Need/Strength:

- ❑ Potential for improvement in eating skills
- ❑ Needs intervention to maintain eating skills
- ❑ _____

Related to:

Cognition/impaired mental deficit: Behavior problem Sequence problem

Diagnosis: Alzheimer's Disease CVA Dementia Fractured hip: left right

Physical limitations Amputation Grasp poor (holding rail, walker etc) Motor skills impaired: Fine Gross

Pain Paralysis: Rt. Left ROM limited: _____ Tires easily Visual impairment Weakness

Weight-bearing status partial

Psychosocial/mood issues: Anxiety Avoids care participation Depression Mood problem

Motivation deficit

Intervention: **Dis:**

- ❑ Explain to resident that is time to eat **N NA**
- ❑ Devices: Apply Hand to resident Place near resident Put in resident's hand **N NA**
- ❑ Type: Regular: Spoon Fork Knife Built-up: Spoon Fork Knife **N NA**
  Rocker: Spoon Fork Knife Plate guard
  Non-skid device under plate Cup Sippe Deep dish plate **N NA**
- ❑ Provide support: Supervision Cues Demonstration One person Feed as needed **N NA**
- ❑ Remind resident to: take small bites to chew and swallow each bite **N NA**
  to use the tongue to move food in the mouth to avoid pocketing
- ❑ Remove adaptive equipment
- ❑ _____

Goal:

Resident will demonstrate improvement in self-feeding skills as evidenced by will feed self

independently with verbal cues with limited assist with extensive assistance

__ % of each meal by through _____

Resident will feed self finger food pierce food with fork Scoop with a spoon Bring cup to mouth

independently with verbal cues with limited assist with extensive assistance

by through

Resident will need less eating support as evidenced by no support one person support by through_____

Resident will maintain current support level as evidenced by no support one person support through_____

_____

Signature/Title: _____ Date(s):_____

Restorative Progress Notes: Eating

Month/Year: _____

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Time															
Breakfast Minutes															
Lunch Minutes															
Dinner Minutes															
Response															
Initials															

DATE	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time																
Breakfast Minutes																
Lunch Minutes																
Dinner Minutes																
Response																
Initials																

Response Key: T = Tolerated R = Refused H = Health appointment S = Sick
*** See appetite flow sheet for percentage of meal consumption**

Progress Notes/Evaluation:

Result Improvement Maintenance

Resident required verbal cues for eating
Resident required limited assistance for eating
Resident required extensive assistance with eating

(Discuss presence of the following issues: spillage from the fork, spoon, plate or pocketing of food difficulty swallowing or chewing and referral needs)

_____
_____
_____
_____
_____

Signature/Title _____

Restorative Nursing Referral Form

Date: _____

Resident: _____

Reason for referral:

Resident would benefit from the following program (s):
Resident no longer appropriate for therapy, but would benefit from ongoing intervention
Describe specific issue: _____
_____
_____
_____

Suggested Program(s):

Amputation
Bed Mobility
Brace assistance
Communication
Dressing
Eating (Dining)
Grooming
Prosthesis Care
Range of Motion
Splint assistance
Swallowing
Toilet in Advance of Need (Scheduled toileting)
Transfer Training
Walking/ambulation
_____

Referral Source:
Physical Therapy
MDS Department
Nursing Staff
Dietary Department
Activity Department
MDS Department
MDS Department
_____

Signature/Title: _____

Restorative Nursing Assignment Sheet

Restorative Aide	Assigned to Residents with #	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							
❑ _____ ❑ _____ ❑ _____	❑ 1 ❑ 2 ❑ 3							

Restorative Nursing Master List

Resident	#	Program	Suggested Delivery Schedule	Comments

Exhibit C

Restorative nursing tools provided by B.J. Collard
"The four P's of restorative nursing"
"Roles and responsibilities in restorative nursing"
"Restorative nursing transfer and documentation form"
"Restorative program unit master list"
"Restorative nursing flow sheet"
"Quality indicator resident level review"

Source: *Permission to reprint by B.J. Collard, RN, BSN, GNP, ANP, CPHQ*

THE FOUR P'S OF RESTORATIVE NURSING

BASIC PROGRAMS	FOCUS
1. Ambulation Programs	**P**romote Mobility
.	
2. Incontinent Management	**P**romote Bowel and Bladder Function
3. Range of Motion (ROM) Programs	**P**revent Contractures
4. Skin Management	**P**revent Skin Breakdown
5. ADL and Restorative Dining Programs	**P**romote Ability to Perform ADLS
6. Sensory Stimulation Classes	**P**reserve Orientation Level
Cognitive Orientation Classes	
7. Socialization Opportunities and Activities	**P**reserve Emotional Health and
One to One programs	**P**romote Social Functioning
8. Communication Programs and	**P**romote Communication
Interventions	
9. Integration of Religious/Spiritual Daily Routine	**P**romote spiritual well being
10. Assistance With Dealing With End of Life Issues	**P**repare for Death

RESTORATIVE PROGRAMS UNDER MDS SECTION P3

a. Range of Motion (Passive) – The extent to which, or the limits between which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a progam of passive or active movements to maintain flexibility and useful motion in the joints of the body.

b. Range of motion (Active) – Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

c. Splint or brace assistance – Assistance can be of 2 types: 1) when staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. these sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice in: - – Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under supervision of a licensed nurse.

d. Bed mobility – Activities used to improve or maintain the resident's self – performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Transfer – Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Walking – Activities used to improve or maintain the resident's self performance in walking, with or without assistive devices.

g. Dressing or grooming – Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing and performing other personal hygiene tasks.

h. Eating or swallowing – Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

i. Amputation/Prosthesis Care – Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).

j. Communication – Activities used to improve or maintain the resident's self performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

k. Other – Any other activities used to improve or maintain the resident's self performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care and cardiac rehabilitation.

ROLES AND RESPONSIBILITIES IN RESTORATIVE NURSING

RESTORATIVE NURSE COORDINATOR

LIASON BETWEEN THERAPY & NURSING
OVERSIGNTS THE PROGRAM – HOW ARE PROGRAMS GOING
PROBLEM SOLVE WHEN PROGRAMS ARE NOT GOING AS EXPECTED
ORGANIZES THE PROGRAM WORKS WITH NURSES TO SEE PROGRAMINFORMATIONIS CURRENT
1:1 WITH STAFF
REPORTS PROGRAM STATUS TO NURSING ADMINISTRATION
CONSULTS WITH STAFF WHEN PROGRAMS ARE NOT GOING AS EXPECTED
CONSULTS WITH THERAPY AS INDICATED

NURSES

HOLDS CNAS ACCOUNTABLE FOR DOING THE PROGRAM AND DOCUMENTING THE PROGRAM
KEEPS THE PROGRAM CURRENT ON THE UNIT – MASTER LIST
COMUNICATES PROGRAMS TO CNNAS VERBALLY AND IN WRITING –
ASSESSES RESIDENTS WHEN NOT RESPONDING TO THE PROGRAM AS EXPECTED
CONSULTS WITH RESTORATIVE NURSE AND/OR THERAPY AS IDICATED

MDS COORDINATOR

POINT PERSON
OVERSEES CODING ACCURACY, PARTICULAR EMPHASIS TO SECTION G

CNAS

IMPLEMENTS THE PROGRAMS
DOCUMENTS THEPROGRAMS
KEEPS CHARGE NURSE INFORMED OF STATUS OF THE PROGRAM
DOCUMENTS AND COMMUNICATES WHEN THE PROGRAM IS NOT GOING AS EXPECTED.

THERAPY

REFERRAL SOURCE –DURING THERAPY, UPON DISCHARGE, UPON NOTIFICATION OF A RESIDENT'S CHANGE IN FUNCTIONAL STATUS
CONSULTANTS TOMORE COMPLEXT RESIDENTS
EDUCATION –LEVEL II DELEGATED TASKS, TRAINING SKILLS AND TECHNIQUES

DON

POLICIES, PROCEDURES, JOB DESCRIPTIONS
ASSIGNS POSITION TO OVERSIGHT THEPROGRAM
OVRSEES STAFFING AND CLINICAL
SETS AND SUPPORTS POLICY THAT LEVEL II IS NOT THE IN HOUSE "POOL" STAFF
MEETS WITH RESTORATIVE COORDINAOTR ON A CONSISTENT BASIS
RESOURCES AND SUPPORT
MAKES THE RESTORATIVE COORDINATOR ACCOUNTABLE (QUESTIONS ABOUT QI'S, ETC.)

ADMINISTRATOR

SETS THE TONE
SUPPORTS THE DEVELOPMENT, COMMITTEE, RESOURCES

RESTORATIVE NURSING TRANSFER AND DOCUMENTATION FORM

Transfer

PROBLEM **Unable to hold feeding utensils in hands & feed self due to severe arthritis in both hands.**

GOAL **Resident will be able to use built up spoon, fork & knife to eat 50% of each meal by 4/7/04.**

PROGRAM/APPROACHES **Restorative dining to provide skill practice for resident to feed herself. Hand utensils to resident. Replace fork & spoon in her right hand & knife in her left when she drops utensils. CNA to place hands firmly over residents hands and guide her when her hands quiver or shake.**
Daffy Duck, OT 4/1/04

F/U VISIT **4/2/04 Repeated instruction & return demonstration on how to firmly hold and guide the hands when they are quivering or shaking. Daffy Duck, OT**

F/U VISIT **4/5/04 The CNA is following the program and providing the instructions appropriately. Resident ate 50% of her noon meal with her utensils. 4/5/04 Daffy Duck, OT**

Demonstration/Instruction 4/1/04 /DD Return Demonstration 1/4/04/GH Master List 1/4/04/ MB
Care Plan Update 4/1/04/ MB Flow Record 4/1/04/MB CNA Assignment 4/1/04/MB

DD – Daffy Duck, OT GH – Glenda Harvey, RCNA
MB –Melon Ball, RN Unit Manager

Progress Note

Admission: **4/1/04 Resident was unable to feed herself because she could not grasp regular feeding utensils due to arthritic pain and joint changes. She was fitted with built up utensils and worked with OT for 2 weeks and transferred today to the Restorative Dining program. Skill practice will continue in the Restorative Dining program. See goal and program above.**
Hazel Nut, LPN, Restorative Nurse

Weekly Progress: **4/8/04 Resident was able to place utensils in her hands when staff handed the utensils to her. She drops the utensil approximately 4 – 5 times at each meal, and more frequently at supper as she reports she is tired by dinner. She is using the utensils for approximately 25 % of meals. Will continue goal and program.**
Hazel Nut, LPN Restorative Nurse

Weekly Progress: **4/15/04 Resident has increased her ability to use her utensils and is able to use them without dropping them for 50 % of all meals. Goal was changed to 100 % of all meals by 4/3/04. Hazel Nut, LPN, Restorative Nurse**

Weekly Progress: **4/22/04 Resident is able to feed herself 100 % of breakfast with no interventions from the CNA and without dropping utensils. She requires staff placement of their hands firmly on hers approximately 2 – 3 times for lunch and supper. Hazel Nut, LPN, Restorative Nurse**

Weekly Progress: **4/29/04 Resident is able to use her utensils to feed herself all 3 meals most of the time. She occasionally needed staff firm hand placement a few times at supper and dropped her fork once during lunch. Will keep her in Restorative Dining for one more week to assure she is able to handle her utensils independently, then will transfer to level III regular dining room.**
Hazel Nut, LPN, Restorative Nurse

RESTORATIVE PROGRAMS UNIT MASTER LIST

AMBULATION | RANGE OF MOTION | SPLINTS/BRACES/CONES | DRESSING/GROOMING | RESTORATIVE DINING

BED MOBILITY | TRANSFER | COMMUNICATION | ASSISTIVE FEEDING DEVICES | OTHER

RESTORATIVE NURSING FLOW SHEET

MONTH_____ YEAR_____

PRESCRIPTION		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ROM	#1																															
Type: Involved Extremities: #3	#2																														Schedule:	
AMPUTATON/PROSTHESIS CARE	#1																															
	#2																															
	#3																															
SPLINT/ BRACE ASSISTANCE:	#1																															
	#2																															
	#3																															
DRESSING GROOMING TRAINING	#1																															
	#2																															
	#3																															
EATING SWALLOWING TRAINING	#1																															
	#2																															
	#3																															
Daily Minutes																																

Instructions: Record # of minutes/session in box with initials. Example: 15/CG The numbers (#) are for the various sessions over 24 hours.

CNA Signature/Initials _____

Resident Name:_____ ID Number_____

QUALITY INDICATOR RESIDENT LEVEL REVIEW
PHYSICAL FUNCTIONING DOMAIN #18 Incidence of Decline in ROM

Facility % ____ Comparison Group % ____ Percentile Rank ____ MDS ARD ____ QI Report Period _____ to _____
MDS Items Involved: G4a-f **Exclusions:** Residents with maximal loss of ROM at previous assessment. (Sum G4a-f, Box A is 12 on previous assessment.)
Numerator: Residents with increases in functional limitation in ROM between previous and most recent assessments.
Denominator: All residents with previous and most recent assessments with the exclusions noted. **Risk Adjustment:** None

I. Resident Sample ID Number:

1. Was the MDS scored accurately during the assessment period? **Yes__ No__**
2. Was there documented evidence staff had addressed the risk for contractures? **Yes__ No__**
3. Was there documented evidence the staff had addressed the decline? **Yes__ No__**
4. Was a Restorative Nursing ROM Program indicated? **Yes__ No__**
If no, explain _____
If yes, answer the following questions:
Was the program on the care plan? **Yes__ No__**
Is there documented evidence the program has been carried out by staff as stated on the care plan? **Yes__ No__**
Is staff observed to be carrying out the program during observation today? **Yes__ No__**
5. Was therapy indicated? **Yes__ No__**
If no, explain_____
6. Is there documented evidence the Resident Assessment Protocol (RAP) for physical functioning was reviewed? **Yes__ No__**
Conclusion Summary: _____
_____
_____

Avoidable Unavoidable

II. Resident Sample ID Number:

1. Was the MDS scored accurately during the assessment period? **Yes__ No__**
2. Was there documented evidence staff had addressed the risk for contractures? **Yes__ No__**
3. Was there documented evidence the staff had addressed the decline? **Yes__ No__**
4. Was a Restorative Nursing ROM Program indicated? **Yes__ No__**
If no, explain _____
If yes, answer the following questions:
Was the program on the care plan? **Yes__ No__**
Is there documented evidence the program has been carried out by staff as stated on the care plan? **Yes__ No__**
Is staff observed to be carrying out the program during observation today? **Yes__ No__**
5. Was therapy indicated? **Yes__ No__**
If no, explain_____
6. Is there documented evidence the Resident Assessment Protocol (RAP) for physical functioning was reviewed? **Yes__ No__**
Conclusion Summary: _____
_____
_____

Avoidable Unavoidable

III. Resident Sample ID Number:

1. Was the MDS scored accurately during the assessment period? **Yes__ No__**
2. Was there documented evidence staff had addressed the risk for contractures? **Yes__ No__**
3. Was there documented evidence the staff had addressed the decline? **Yes__ No__**
4. Was a Restorative Nursing ROM Program indicated? **Yes__ No__**
If no, explain _____
If yes, answer the following questions:
Was the program on the care plan? **Yes__ No__**
Is there documented evidence the program has been carried out by staff as stated on the care plan? **Yes__ No__**
Is staff observed to be carrying out the program during observation today? **Yes__ No__**
5. Was therapy indicated? **Yes__ No__**
If no, explain_____
6. Is there documented evidence the Resident Assessment Protocol (RAP) for physical functioning was reviewed? **Yes__ No__**
Conclusion Summary: _____
_____
_____

Avoidable Unavoidable

IV. Resident Sample ID Number:

1. Was the MDS scored accurately during the assessment period?	**Yes__ No__**
2. Was there documented evidence staff had addressed the risk for contractures?	**Yes__ No__**
3. Was there documented evidence the staff had addressed the decline?	**Yes__ No__**
4. Was a Restorative Nursing ROM Program indicated?	**Yes__ No__**
If no, explain _____	
If yes, answer the following questions:	
Was the program on the care plan?	**Yes__ No__**
Is there documented evidence the program has been carried out by staff as stated on the care plan?	**Yes__ No__**
Is staff observed to be carrying out the program during observation today?	**Yes__ No__**
5. Was therapy indicated?	**Yes__ No__**
If no, explain_____	
6. Is there documented evidence the Resident Assessment Protocol (RAP) for physical functioning was reviewed?	**Yes__ No__**

Conclusion Summary: _____

_____

_____

Avoidable Unavoidable

V. Resident Sample ID Number:

1. Was the MDS scored accurately during the assessment period?	**Yes__ No__**
2. Was there documented evidence staff had addressed the risk for contractures?	**Yes__ No__**
3. Was there documented evidence the staff had addressed the decline?	**Yes__ No__**
4. Was a Restorative Nursing ROM Program indicated?	**Yes__ No__**
If no, explain _____	
If yes, answer the following questions:	
Was the program on the care plan?	**Yes__ No__**
Is there documented evidence the program has been carried out by staff as stated on the care plan?	**Yes__ No__**
Is staff observed to be carrying out the program during observation today?	**Yes__ No__**
5. Was therapy indicated?	**Yes__ No__**
If no, explain_____	
6. Is there documented evidence the Resident Assessment Protocol (RAP) for physical functioning was reviewed?	**Yes__ No__**

Conclusion Summary: _____

_____

_____

Avoidable Unavoidable

Use the Quality Indicator Facility/System Level Review Form to apply the QI process when improvement areas are identified. When there are no areas needing improvement, report through QI and file the documentation. Share the positive outcomes with your staff.

Reviewer Signature/Title: Date Review Completed:

Guidelines and Definitions

Functional limitation is the key in scoring Section G4, Functional Limitation in Range of Motion. Limitation in ROM, as defined in the MDS User's Manual, is limitation that interferes with daily functioning; particularly with activities of daily living or places the resident's at risk for injury.

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QUALITY INDICATOR FACILITY/SYSTEM LEVEL REVIEW

(When resident level review identifies areas needing improvement, apply the QI process to the related system.)

Domain:_____ Quality Indicator_____Percentage_____

I. IMPROVEMENT AREAS (Check the boxes that apply based on the resident level review and define the improvement areas. Consider the entire sample and the severity of one or more cases.)

☐ **Pattern of inaccurate MDS coding**

_____
_____
_____
_____

☐ **Pattern of care issues/deficient practice**

_____
_____
_____
_____

☐ **Could this be an immediate jeopardy situation? (Before answering, review the worksheet on the attached page.) Yes ___ No ___**

If yes, proceed with questions. Was the facility aware of this situation? Yes ___ No ___ If aware, when and how?

_____

If not aware, should they have been?

_____

II. INVESTIGATION (WHY? WHAT IS THE ROOT CAUSE?)

_____
_____
_____
_____
_____
_____
_____

III. ACTION PLAN

_____
_____
_____
_____
_____
_____

Reviewer Signature/Title:_____**Date:**_____

IV. FOLLOW UP

_____
_____
_____
_____
_____
_____

Reviewer Signature/Title_____ **Date:**_____

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Resources

Other sites

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CERTIFICATE OF ATTENDANCE

attended

"Realize the Benefits of Restorative Nursing: How to Improve Reimbursement and Your Residents' Quality of Life"

a 90-minute audioconference

on

September 24, 2004

Suzanne Perney

HCPro, Inc.

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Education Program Schedule Fall 2004

OCTOBER

Loews Philadelphia Hotel, Philadelphia, PA

6th
The Problem Physician: *How to assess and manage impaired, dyscompetent and disruptive physicians*

7-8th
Medical Staff Quality: *How to improve peer review, patient safety, and clinical outcomes*
Advanced Medical Staff Leadership Retreat I: *How to resolve today's toughest medical staff challenges*

Eldorado Hotel, Santa Fe, NM

21-22nd
Legal Issues for Medical Leadership: *How to stay out of trouble and stay out of court*
Credentialing and Privileging: *What physician leaders and credentialing professionals must know today!*

NOVEMBER

The Ritz-Carlton New Orleans, New Orleans, LA

4-5th
Patient Safety and Medical Error Reduction: *How to identify and eliminate the real causes of medical error*
Advanced Medical Staff Leadership Retreat II: *Leadership solutions for managing ongoing dilemmas*

The Ritz-Carlton Palm Beach, Palm Beach, FL

17th
VPMA Retreat: *Opportunities, constraints, and challenges of the VPMA/CMO role*

18-19th
Medical Executive Committee Institute: *The essential training program for all medical staff leaders*
Effective JCAHO Survey Preparation for the Medical Staff

19-20th ***New Seminar!***
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